THE NORTHWESTERN MUTUAL LIFE INSURANCE COMPANY
720 E. WISCONSIN AVENUE, MILWAUKEE, WISCONSIN 53202

LIFE INSURANCE APPLICATION 16952105

LIFE INSURANCE APPLICATION Page 1

INSURED NAME (First, Middle Initial, Last): Kenneth Wilson

POLICY NUMBER: 16852093 326366

☐ Companion policies ☐ Life & Disability Application
☐ APB Option ☐ Exam (NM, PME, MD) in Home Office

Plan Group Number:

INSURED

Has an application or informal inquiry ever been made to Northwestern Mutual Life for annuity, life, or disability insurance on the life of the Insured? ☐ Yes ☐ No If yes, the last policy number is _____

A. ☒ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other _____

B. ☒ MALE ☐ FEMALE

C. BIRTHDATE (Month, Day, Year): 12/31/1968

D. STATE OF BIRTH (or Foreign Country): NY

E. TAXPAYER IDENTIFICATION NUMBER: 111-68-2549

F. PRIMARY RESIDENCE:
STREET OR PO BOX: 70 Brookside Place
CITY, STATE, ZIP (Country if other than U.S.A.): New Rochelle, NY 10801

APPLICANT

Select ONLY ONE: ☒ Insured at Insured's Address OR ☐ Other (Complete A, B and C)

A. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other _____
PERSONAL NAME: _____ ☐ MALE ☐ FEMALE
(FIRST, MIDDLE INITIAL, LAST)
RELATIONSHIP TO INSURED: _____ BIRTHDATE: _____ (MONTH DAY YEAR)
OR
BUSINESS/TRUST NAME: _____
TYPE OF ORGANIZATION: ☐ Trust ☐ Corporation ☐ Partnership ☐ Other type of Business _____
AUTHORIZED COMPANY REP/TRUSTEE NAME: _____

B. TAXPAYER IDENTIFICATION NUMBER: _____

C. ADDRESS: STREET OR PO BOX: _____
CITY, STATE, ZIP (Country if other than U.S.A.): _____

PREMIUM PAYER

Select ONLY ONE: ☒ ISA (Omit A through D below) OR ☐ Insured (Complete D only) ☐ Applicant (Complete D only) ☐ Owner (Complete D only) ☐ Other (Complete A, B, C and D)

A. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other _____
PERSONAL NAME: _____ ☐ MALE ☐ FEMALE
(FIRST, MIDDLE INITIAL, LAST)
BIRTHDATE: _____ (MONTH DAY YEAR)
OR
BUSINESS/TRUST NAME: _____

B. TAXPAYER IDENTIFICATION NUMBER: _____ C. DAYTIME TELEPHONE NUMBER: Area Code ( )

Send premium and other notices regarding this policy to:
D. ADDRESS: ☐ Insured's Address ☐ Applicant's Address OR
STREET OR PO BOX: _____
CITY, STATE, ZIP (Country if other than U.S.A.): _____

OWNER (CAUTION: A MINOR OWNER CANNOT EXERCISE POLICY RIGHTS.)

Select ONLY ONE: ☒ Insured (Complete C only) ☐ Applicant (Complete C only) ☐ Other (Complete A, B and C) ☐ See attached supplement form

A. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other _____
PERSONAL NAME: _____ ☐ MALE ☐ FEMALE
FIRST, MIDDLE INITIAL, LAST
RELATIONSHIP TO INSURED: _____ BIRTHDATE: _____ (MONTH DAY YEAR)
OR
BUSINESS/TRUST NAME: _____
RELATIONSHIP TO INSURED: _____

B. TAXPAYER IDENTIFICATION NUMBER: _____

C. ADDRESS: ☐ Insured's Address ☐ Applicant's Address ☐ Premium Payer's Address OR
STREET OR PO BOX: _____
CITY, STATE, ZIP (Country if other than U.S.A.): _____

5 RESERVED

6 **SUCCESSOR OWNER** - COMPLETE THIS SECTION ONLY IF THE OWNER IN QUESTION 4 IS THE APPLICANT AND A SUCCESSOR OWNER IS TO BE NAMED.
(CAUTION: A MINOR OWNER CANNOT EXERCISE POLICY RIGHTS.)
Select ONLY ONE:
☐ A. If the Applicant dies before the Insured, the Insured will be the Owner.
☐ B. If the Applicant dies before the Insured, the Owner will be:
NAME: _____ RELATIONSHIP TO THE INSURED
If both die before the Insured, the Insured will be the Owner.
☐ C. The Insured will become the Owner upon attaining the age of ____ years. If the Applicant dies before the Insured, the Owner will be:
NAME: _____ RELATIONSHIP TO THE INSURED
until the Insured attains such age. Upon the Insured attaining such age, or if both die before the Insured, the Insured will be the Owner.

7 **ADDITIONAL PURCHASE BENEFIT OPTION** – COMPLETE THIS SECTION IF EXERCISING AN APB OPTION (NOTE: SMOKING QUESTIONNAIRE MAY BE REQUIRED)
A. List the policy number(s) and purchase amount(s) for each option being exercised:
Policy 1 _____ Regular $ _____ Advance $ _____
Policy 2 _____ Regular $ _____ Advance $ _____
Policy 3 _____ Regular $ _____ Advance $ _____
B. If Advance Purchase, the event is: ☐ Marriage ☐ Birth of child ☐ Adoption of child
NAME OF SPOUSE OR CHILD: _____ (FIRST / MIDDLE INITIAL / LAST)
Date and place of marriage, birth or final decree of adoption: _____ (MONTH / DAY / YEAR) _____ (CITY / STATE)
C. Is the amount applied for more than the additional purchase option amount available? ☐ Yes ☐ No
If yes, what is the excess amount to be underwritten? $ _____

8 **SPECIAL DATE** – COMPLETE THIS SECTION ONLY IF A SPECIAL POLICY DATE IS BEING REQUESTED
A. PREPAID:
☐ Short Term — Policy Date will coincide with ISA Payment Date (For monthly ISA only)
☐ Short Term to: _____ (MONTH / DAY / YEAR) ☐ Date to save age ☐ Backdate to _____ (MONTH / DAY / YEAR)
B. NONPREPAID:
☐ Specified future date: _____ (MONTH / DAY / YEAR) ☐ Date to save age ☐ Backdate to _____ (MONTH / DAY / YEAR)

9 **POLICY APPLIED FOR**
☒ Term Insurance Plan (Complete A and B). OR ☒ See attached supplement for plans other than term insurance
A. Plan and Amount
(1) PLAN: _____ AMOUNT: _____
(2) PLAN: 350,000 J T 15 AMOUNT: _____
B. ADDITIONAL BENEFITS:
(1) ☒ Waiver of Premium
☐ Accidental Death $ _____
☐ Indexed Protection
☐ Other _____
(2) ☒ Waiver of Premium
☐ Accidental Death $ _____
☐ Indexed Protection
☐ Other _____

10 If an additional benefit cannot be approved, should the company issue a policy without the benefit? ☒ Yes ☐ No

11 Shall the Premium Loan provision, if available, become operative according to its terms? ☒ Yes ☐ No

12 ANNUAL DIVIDENDS until otherwise directed will:

Policy 1	Policy 2	
☐	☒	Reduce current premium
☒	☐	Purchase paid-up additions - If the plan has Additional Protection or Adjustable Term Protection, additions purchased by eligible dividends will be used to: ☐ Reduce term insurance _____% ☐ Increase Coverage _____%
☐	☐	Accumulate at interest
☐	☐	Be paid in cash
☐	☐	Be used for a combination of options above - complete form 18-1364-01

13 POLICY LOAN INTEREST RATE OPTION: ☒ 8% ☐ Variable Rate

14 PREMIUM FREQUENCY: ☒ Annually ☐ Semiannually ☐ Quarterly ☐ Single

INSURED NAME (First, Middle Initial, Last) | POLICY NUMBER 326366

BENEFICIARY

A. DIRECT BENEFICIARY (First, Middle Initial, Last / Relationship to Insured)
1. Michelle A. Wilson
2.
3.
BUSINESS ORGANIZATION OR TRUST

B. CONTINGENT BENEFICIARY (First, Middle Initial, Last / Relationship to Insured)
1. Estate of the Insured
2.
3.

Box (1) or (2) may be selected to include all of the children or brothers and sisters without naming them, or to add to the contingent beneficiaries named. Box (3) may be selected to provide for the children of a deceased contingent beneficiary; use only if contingent beneficiaries are named and/or Box (1) or (2) is checked. NOTE: The word "children" includes child and any legally adopted child.

☐ (1) and all (other) children of the Insured.

☐ (2) and all (other) brothers and sisters of the Insured born of the marriage of or legally adopted by _____ and _____ before the Insured's death.

☐ (3) any amount that would have been paid to a deceased contingent beneficiary, if living, will be paid in one sum and in equal shares to the children of that contingent beneficiary who survive and receive payment.

C. FURTHER PAYEES (First, Middle Initial, Last / Relationship to Insured)

D. SEE ATTACHED SUPPLEMENT FORM (To be used in place of designations above.)

TRUSTEE AS BENEFICIARY If a trustee is named as a beneficiary and no qualified trustee makes claim to the proceeds, or to the present value of any unpaid payments under a payment plan, within one year after payment becomes due to the trustee, or if satisfactory evidence is furnished to the Company within that year showing that no trustee can qualify to receive payment, payment will be as provided in the contract as though the trustee had not been named. The Company will be fully discharged of liability for any action taken by the trustee and for all amounts paid to, or at the direction of, the trustee and will have no obligation as to the use of the amounts. In all dealings with the trustee the Company will be fully protected against the claims of every other person. The Company will not be charged with notice of a change of trustee unless written evidence of the change is received at the Home Office.

18 RESERVED

Has the premium for the policy applied for been given to the agent in exchange for the Conditional Life Insurance Agreement with the same number as this application? ☑ Yes ☐ No

A. Will the insurance applied for replace any Northwestern Mutual Life Insurance (or annuities) on the Insured's life? ☐ Yes ☑ No
If yes, agent should explain and send required papers.

B. Will the insurance applied for replace life insurance (or annuities) on the Insured's life from a source other than the Northwestern Mutual Life? ☐ Yes ☑ No
If yes, agent should explain and send required papers.

C. Will the replacement result in a 1035 exchange? ☐ Yes ☑ No
If yes, agent should explain and send required papers.

EXPLANATION:

19 RESERVED

PERSONAL HISTORY QUESTIONNAIRE

☐ Payor Benefit for Applicant (Payor) _____ (FIRST / MIDDLE INITIAL / LAST)

Payor's Date of Birth ____ (MONTH) - ____ (DAY) - ____ (YEAR) Policy Number _____ Relationship to Insured _____

20 Has the Insured ever had life, disability or health insurance declined, rated, modified, issued with an exclusion rider, cancelled, or not renewed? If yes, explain in ADDITIONAL REMARKS. ☐ Yes ☒ No

21 When was the Insured's last examination or application for life, disability or accidental death insurance?
Month _____ Year 2002 Company William Penn OR ☐ None

22 Indicate below whether any other life insurance on the Insured is Individual (Ind) or Group (Grp) and identify In Force (I), Pending (P) or Contemplated (C) or ☐ NONE.

Company Name	Ind or Grp	In Force Amount	Pending Amount	Contemplated Amount	Accidental Death Amount
William Penn		1,000,000			
William Penn		500,000			

23 Insured's Marital Status: ☐ Single, Widowed or Divorced ☒ Married

24 A. Insured is a citizen of: ☒ U.S.A. ☐ Other
If other: Type of Visa _____ Visa Number _____
B. How many years has the Insured resided in the U.S.A. immediately prior to completing this application? 35 years

25 Does the Insured regularly travel outside the U.S.A. or have plans to leave the U.S.A. for travel or residence? ☐ Yes ☒ No
If yes, explain in the chart below.

Destination (List all Cities and Countries)	Number of Trips Last 12 Months	Number of Trips Next 12 Months	Duration of Each Trip (No. of Days)	Departure Date (Month/Year)	Purpose of Trip

26 A. What is the Insured's occupation(s)? Bank Officer
What are the Insured's duties? Product Manager
B. Employer's Name: J.P Morgan Chase
Address: 1 Chase
City, State, Zip Code: NY, NY 10081
C. How long has the Insured been employed? 11 yrs. years (If less than 2 years, explain in ADDITIONAL REMARKS)

QUESTIONS 27 THROUGH 30 ARE NOT REQUIRED IF THE INSURED IS UNDER AGE 16.

27 Is the Insured a member of, or does the Insured plan on joining any branch of, the Armed Forces or reserve military unit? If yes, complete the Military Section. ☐ Yes ☒ No

28 Except as a passenger on a regularly scheduled flight, has the Insured flown within the past 2 years, or does the Insured have plans to fly in the future? If yes, complete the Aviation Section. ☐ Yes ☒ No

29 In the past 2 years, has the Insured participated in or does the Insured have plans to participate in: racing (automobile, snowmobile, motorcycle, boat or go-cart), underwater or sky diving, hang gliding, bungee jumping, mountain or rock climbing, or rodeos? If yes, complete the Avocation Section. ☐ Yes ☒ No

30 A. What is the Insured's automobile driver's license number? # 107 208 268 State NY
or, ☐ the Insured does not have a driver's license.
B. In the past 5 years, has the Insured been in a motor vehicle accident, has the Insured been convicted of a moving violation of any motor vehicle law, or has the Insured's driver's license been restricted, suspended or revoked? ☐ Yes ☒ No
If yes, complete the chart below.

Date	Type and Details (Speeding, Reckless Driving, Driving While Intoxicated, Etc.)	Action (Citation, Fine, Etc.)	Accident (Yes or No)

ADDITIONAL REMARKS

INSURED NAME (First, Middle Initial, Last)	POLICY NUMBER
	326366

The Insured consents to this application and declares that the answers and statements made on this application are correctly recorded, complete and true to the best of the Insured's knowledge and belief. Answers and statements brought to the attention of the agent, medical examiner, or paramedical examiner are not considered information brought to the attention of the Company unless stated in the application. Statements in this application are representations and not warranties.

It is agreed that:

(1) If the premium is not paid when the application is signed, no insurance will be in effect. The insurance will take effect at the time the policy is delivered and the premium is paid, if: the Insured is living at the time; and the answers and statements in the application are then true to the best of the Insured's knowledge and belief.

(2) If the premium is paid when the application is taken, no insurance will be in effect except as provided in the Conditional Life Insurance Agreement with the same number as this application.

(3) If the policy is issued in an extra premium class, acceptance of the policy will amend it so that extended term insurance can be in force only if: the Company gives its consent; or the loan value is not large enough to grant a premium loan. If a premium is not paid within the grace period and extended term insurance cannot be in force, paid-up insurance will be selected.

(4) No agent is authorized to make or alter contracts or to waive any of the Company's rights or requirements.

INSURED'S AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize The Northwestern Mutual Life Insurance Company, its agents, employees, reinsurers, insurance support organizations and their representatives to obtain information about me to evaluate this application and to verify information in this application. This information will include: (a) age; (b) medical history, condition and care; (c) physical and mental health; (d) ; (e) income and financial history; (f) foreign travel; (g) avocations; (h) driving record; (i) other personal characteristics; ( ) insurance. This authorization extends to information on the use of alcohol, drugs and tobacco; the diagnosis or treatment transmitted diseases; and the diagnosis and treatment of mental illness. During the time this authorization is valid it ex information required to determine eligibility for benefits under any policy issued as a result of this application.

I authorize any person, including any physician, health care professional, hospital, clinic, medical facility, government agency including the Veterans and Social Security Administrations, the MIB, Inc., employer, business associates, consumer reporting agency, banker, accountant, tax preparer, or other insurance company, to release information about me to The Northwestern Mutual Life Insurance Company or its representatives on receipt of this authorization. The Northwestern Mutual Life Insurance Company or its representatives may release this information about me to translators, to reinsurers, to the MIB, Inc., or to another insurance company to whom I have applied or to whom a claim has been made. No other release may be made except as allowed by law or as I further authorize.

I have received a copy of the Medical Information Bureau and Fair Credit Reporting Act notices. I authorize The Northwestern Mutual Life Insurance Company to obtain an investigative consumer report on me.

☐ I request to be interviewed if an investigative consumer report is done.

This authorization is valid for 30 months from the date it is signed. A copy of this authorization is as valid as the original and will be provided on request.

The Owner of the policy applied for herein certifies, under penalties of perjury, (1) that the Taxpayer Identification Number given for the Owner on the first page of this application is the Owner's correct Taxpayer Identification Number (or the Owner is waiting for a number to be issued) and (2) the Owner is not subject to backup withholding either because the Owner has not been notified by the Internal Revenue Service (IRS) that the Owner is subject to backup withholding as a result of a failure to report all interest or dividends, or the IRS has notified the Owner that the Owner is no longer subject to backup withholding, and (3) that the Owner is a U.S. person (including U.S. citizen, resident alien, and others as defined by the IRS). (See Taxpayer Identification Number instructions.)

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

The signatures below apply to the authorization, the application and the certification of Taxpayer Identification Number.

♦ _____
Signature of **INSURED** (If other than Applicant and 15 years of age or over)
Print name of Insured if under age 15.

♦ Kenneth E. Wilson
Signature of **APPLICANT**

♦ _____
Signature of **PARENT OR GUARDIAN**
(If other than Applicant and Insured is a minor)

NY, NY
Signed by Applicant at **CITY, COUNTY, STATE**

♦ _____
Signature of **OWNER**
(If other than Applicant or Insured)

DATE Signed by Applicant 05 22 20 4
MONTH DAY

♦ David Stern
Signature of **LICENSED AGENT**

90-1 L.I. (0496) NEW YORK

027458

THE NORTHWESTERN MUTUAL LIFE INSURANCE COMPANY

720 E. WISCONSIN AVENUE, MILWAUKEE, WISCONSIN 53202

PARAMEDICAL QUESTIONNAIRE

INSURED NAME (First, Middle Initial, Last) Kenneth Wilson

Each question must be individually asked and answered. Give details of "Yes" answers below:

	YES	NO
31. Have you used tobacco or nicotine in any form in the last 10 years? If "yes", indicate type and date last used:	☐	☑
☐ Cigarette, pipe, snuff, chewing tobacco, nicotine gum, nicotine patch or other form of nicotine ..... Date last used ___/___/___		
☐ Cigar ..... Date last used ___/___/___ Frequency of cigar use ..... No. per year ___		
32. Are you taking medication or drugs (legal or illegal, prescription or nonprescription) for any reason? If yes, list and explain.	☐	☑
33. In the last 10 years, have you been told you had or been treated for:		
a. Disorder of eyes (including double vision), ears, nose, mouth, throat or speech?	☐	☑
b. Dizziness, loss of balance, headaches, seizures or convulsions, muscle weakness, tremor, paralysis, stroke, memory loss, or any disease of the brain or nervous system?	☐	☑
c. Anxiety, depression, stress, or any psychological or emotional condition or disorder?	☐	☑
d. Persistent shortness of breath, hoarseness, cough, coughing up blood, asthma, emphysema, tuberculosis, or any lung or respiratory disorder?	☐	☑
e. Jaundice, hepatitis, intestinal bleeding, ulcer, hernia, colitis, diverticulitis, recurrent indigestion, or any disorder of the stomach, intestines, liver, gall bladder or pancreas?	☐	☑
f. High blood pressure, chest pain, chest discomfort, chest tightness, irregular heart beat, heart murmur, heart attack or any disorder of the heart or blood vessels?	☐	☑
g. Sugar, albumin, blood or pus in the urine, sexually transmitted or venereal disease, or any disorder of the kidney, bladder, prostate or reproductive organs?	☐	☑
h. Diabetes, thyroid or any glandular (endocrine) disorder?	☐	☑
i. Cancer, tumor, polyp, or disorder of the lymph gland(s) or breast(s)?	☐	☑
j. Anemia, bleeding tendency, or any disorder of the blood?	☐	☑
k. Arthritis, sciatica, gout, or any disorder of the muscles, bones, joints, spine, back or neck?	☐	☑
l. Chronic or unexplained fatigue, fever, or illness?	☐	☑
m. Any allergies?	☐	☑
n. Any disorders of the skin?	☐	☑
o. Deformity, lameness or amputation?	☐	☑
34. a. Have you sought or received counseling or treatment for the use of alcohol or drugs or had any symptoms of alcohol abuse or drug addiction?	☐	☑
b. In the last 10 years, have you used marijuana, cocaine, heroin, amphetamines or hallucinogens?	☐	☑
c. In the last 10 years, have you used any tranquilizers, sedatives or narcotic drugs?	☐	☑
d. In the last 10 years, have you used legally prescribed drugs in excess of dosages prescribed by a physician or medical practitioner?	☐	☑
35. Are you pregnant? If yes, due date: ____ N/A	☐	☐

For all "Yes" responses:
- Identify question numbers.
- State signs, symptoms and diagnosis of each illness or injury.
- List the details and results of any treatment.
- For each health care provider consulted, list the name, full address, telephone number and date.

DETAILS

DOC. RECD AS IS

80-0672 NEW YORK

80-0672-02 (page 1 of 2)

027458

PROPOSED INSURED NAME (First, Middle Initial, Last) Kenneth Wilson

Each question must be individually asked and answered. Give details of "Yes" answers below:

36. Other than as previously stated on this application, in the last five years have you:

	YES	NO
a. Consulted any other health care providers (medical doctor, psychiatrist, psychologist, chiropractor, counselor, therapist or other)?	☐	☑
b. Been a patient in a hospital, clinic or medical facility?	☐	☑
c. Had any diagnostic studies (EKG, x-ray, blood tests or any other, except for an HIV test)?	☐	☑
d. Had surgery?	☐	☑
e. Been advised to have any test, consultation, hospitalization, or surgery which was not completed?	☐	☑

37.

	YES	NO
a. During the last 6 months have you worked in your regular occupation less than your usual number of hours per week because of any sickness or injury?	☐	☑
b. Have you ever requested or received payments, benefits, or a pension because of any injury, accident, sickness or disability?	☐	☑

38.

	YES	NO
a. Do you have a family history of diabetes, cancer, melanoma, heart or kidney disease, mental illness or suicide, or any hereditary disease?	☐	☑

b. Family History

	Age If Living	Medical History or Cause of Death	Age at Death
Father	70	} good	
Mother	63		
Brothers or Sisters	35		

39. Have you lost weight in the past 6 months? YES ☐ NO ☑
If yes, loss was ______ lbs.
Reason for weight loss ______

40. (Do not complete for Disability Insurance)
If the Insured is under age 1, what was the weight at birth? ______ lbs. ______ ozs.

41. Have you ever been diagnosed as having or been treated for AIDS and/or ARC? YES ☐ NO ☑

42. Who is your regular or personal physician, doctor or health care provider? ☐ None
Name: Dr Patel, Sunil
Address: Queens Blvd.
City, State & Zip Code: Forest Hills NY 11375
Date last seen: 2/05 Phone number: (718) 268 1750
Reason: Check up

For all "Yes" responses:
- Identify question numbers.
- State signs, symptoms and diagnosis of each illness or injury.
- List the details and results of any treatment.
- For each health care provider consulted, list the name, full address, telephone number and dates.

DETAILS

DOC. REC'D AS IS

I declare that my answers and statements are correctly recorded, complete and true to the best of my knowledge and belief. Statements in this application are representations and not warranties.

Signed in my presence ➧ ______ ➧ Kenneth E. Wilson
[illegible] EXAMINER Signature of [illegible] (or Parent/Guardian)
05/29/2005
DATE (MM/DD/YYYY)

If you or your provider reside in a state requiring one or more changes to the provisions on page one of this form, then the identified provisions apply to your Authorization.

Arizona

This Authorization is valid for 180 days from the date it is signed for HIV related information.

California

This Authorization includes information on the diagnosis or treatment of AIDS and sexually transmitted diseases.

Kansas

This Authorization is valid for 12 months from the date it is signed.

Maine

This authorization excludes disclosure of the result of a test for HIV if the Insured has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat shall otherwise prohibit this Authorization from including other facts and information relative to the fact that the Insured has AIDS.

Minnesota

This Authorization is valid for 26 months from the date it is signed. The Authorization excludes the release of information about **HBV (Hepatitis B Virus), HCV (Hepatitis C Virus), or HIV (Human Immunodeficiency Virus)** tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards, at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the Good Samaritan law.

New Jersey

This Authorization includes information on the diagnosis or treatment of AIDS and sexually transmitted diseases.

New Mexico

"Confidential abuse information" means information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse or the status of an applicant or insured as a family member, employee or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close personal, family or abuse-related counseling relationship. During the time this authorization is valid it extends to information required to determine eligibility for benefits under any policy issued as a result of this application.
With respect to confidential abuse information, I may revoke this Authorization in writing, effective ten days after receipt by The Northwestern Mutual Life Insurance Company, but that doing so may result in an application or claim being denied or may otherwise adversely affect a pending insurance action.

New York

This Authorization includes information on the diagnosis or treatment of AIDS, ARC, and sexually transmitted diseases.

Oklahoma

This Authorization is valid for 24 months from the date it is signed. **We are required to inform you that the information you authorize for release may include records which may indicate the presence of communicable or venereal diseases, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).**

Oregon

This Authorization is valid for 24 months (or 180 days for HIV related information) from the date it is signed.

Vermont

This Authorization is valid for 24 months from the date it is signed. It excludes the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC. The proposed Insured IS NOT authorizing the Company to forward the results from any new test required by the Company to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services.

The signature on page one of this Authorization acknowledges that the entire Authorization includes the applicable state variations as listed above.

THE NORTHWESTERN MUTUAL LIFE INSURANCE COMPANY
720 East Wisconsin Avenue, Milwaukee, WI 53202

This Authorization complies with the HIPAA Privacy Rule

Authorization for Release of Health-Related Information to The Northwestern Mutual Life Insurance Company

Kenneth Wilson — Name of Patient/Proposed Insured (please print)

12/31/1968 — Date of Birth (MM/DD/YYYY)

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record to The Northwestern Mutual Life Insurance Company (Northwestern Mutual) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By signing below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Northwestern Mutual may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Northwestern Mutual.

This Authorization shall remain in force for 30 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to Northwestern Mutual at 720 East Wisconsin Avenue, Milwaukee, Wisconsin 53202, Attention: Vice President New Business. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that Northwestern Mutual has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that information disclosed to Northwestern Mutual pursuant to this Authorization is no longer covered by the HIPAA Privacy Rule; and that in the course of conducting its business, Northwestern Mutual may release information it has about me to affiliates, reinsurers, and any person performing business or legal service for Northwestern Mutual and as permitted or required by law.

I understand that if I alter, revoke, or refuse to sign this Authorization to release my entire medical record, Northwestern Mutual may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I further understand that My Providers cannot condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization. I acknowledge by my signature below, that I have a right to receive, and have in fact received, a copy of this Authorization.

Kenneth E. Wilson — Signature of Patient/Proposed Insured *(or Parent or Guardian)*

05/22/2004 — Date *(MM/DD/YYYY)*

Relationship to Patient/Proposed Insured

Address of Parent or Guardian, if signing

Some states' rules concerning Authorizations change the terms and provisions above. The terms and provisions on page two of this document are part of this Authorization and apply in the identified states.

SEND ORIGINAL WITH APPLICATION – GIVE A COPY TO PROPOSED INSURED
THE HOME OFFICE WILL ACCEPT A FAX TRANSMISSION OF THIS ORIGINAL, SIGNED DOCUMENT

The Northwestern Mutual Life Insurance Company
731 East Wisconsin Avenue
Milwaukee, Wisconsin 53202

DOC. REC'D AS IS

Northwestern Long Term Care Insurance Company
Administration Office, P.O. Box 5700
Hopkins, Minnesota 55343-5700

NEW YORK NOTICE AND CONSENT FOR AIDS-RELATED BLOOD OR SALIVA TESTING

To evaluate your insurability, the insurer named above (the Insurer) has requested that you provide a sample of your blood or saliva for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibody or antigens. By signing and dating this form, you agree that this test may be done and that underwriting decisions will be based on the test results. A series of at least three tests will be performed by a licensed laboratory through a medically accepted procedure. These tests may include enzyme-linked immunosorbent assay tests and a Western blot test.

MEANING OF POSITIVE TEST RESULT

The test is not a test for AIDS. It is a test for antibodies to or antigens of HIV, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS, but that you are at significantly increased risk of developing problems with your immune system. The HIV test is very sensitive and specific. Errors are very rare, but they could occur. If your test result is positive, you may wish to consider further independent testing. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test. Positive HIV test results mean that your insurance application will be declined.

CONFIDENTIALITY OF TEST RESULTS

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary in connection with insurance you have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers or employees. If your HIV test is abnormal, a generic code signifying a nonspecific blood or saliva abnormality may be made known to the Medical Information Bureau (MIB, Inc.) as described in the notice given at the time of application. The fact that the test has been done and the results of the test will not otherwise be disclosed except as may be required by law or as authorized by you.

NOTIFICATION OF TEST RESULTS

If your test results are negative, no routine notification will be sent to you. If your test results are other than normal, you are entitled to that information if you so desire. You are asked to designate a physician to receive abnormal test results. This physician can best discuss the test results with you and explain their significance. Please provide the following information about your personal physician (or other person to whom you would like positive test results disclosed):

PHYSICIAN'S NAME	STREET ADDRESS	
CITY	STATE	ZIP CODE

If you would prefer to have the test results sent to you at the address given below, initial here. KW

FURTHER INFORMATION

For further information about AIDS, the meaning of AIDS-related test results, and the availability and location of AIDS-related counselling services, contact the Department of Health through its state-wide toll-free telephone number, 1-800-541-AIDS.

CONSENT

I have read and I understand this Notice and Consent for AIDS-Related Blood or Saliva Testing. I voluntarily consent to provide a sample of blood or saliva from me, the testing of that blood or saliva and the disclosure of the test results as described above. A photocopy or facsimile of this form will be as valid as the original. I further acknowledge receipt of a copy of this form signed by me.

Kenneth E. Wilson — 05/29/04

SIGNATURE OF PROPOSED INSURED (OR PARENT / GUARDIAN) — DATE SIGNED (MM/DD/YYYY)

NAME OF PROPOSED INSURED (PRINT)		DATE OF BIRTH (MM/DD/YYYY)	
Kenneth Wilson		12/21/1964	
STREET ADDRESS	CITY	STATE	ZIP CODE
70 Brookside Place	New Rochelle	NY	10801

17-8000 (9107) New York — SEND ORIGINAL WITH APPLICATION/EXAM — GIVE A COPY TO PROPOSED INSURED — THE HOME OFFICE WILL ACCEPT A FAX TRANSMISSION OF THIS ORIGINAL, SIGNED DOCUMENT — WORD 6-PE

REPLICA

It is recommended that you . . .

read your policy.

notify your Northwestern Mutual agent or the Company at 720 East Wisconsin Avenue, Milwaukee, Wisconsin 53202, of an address change.

call your Northwestern Mutual agent for information -- particularly on a suggestion to terminate or exchange this policy for another policy or plan.

Election Of Trustees

The members of The Northwestern Mutual Life Insurance Company are its policyholders of insurance policies and deferred annuity contracts. The members exercise control through a Board of Trustees. Elections to the Board are held each year at the annual meeting of members. Members are entitled to vote in person or by proxy.

TERM LIFE POLICY

Participating

Insurance payable on death of Insured before Expiry Date. Convertible on or before the Final Conversion Date. Premiums are payable to the Expiry Date shown on page 3.

RS.TERM.(042000)

Exhibit C

JUH-1961 (05/2003)

REGISTRAR'S DISTRICT NO. 2047
REGISTER NUMBER 391

NEW YORK STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RESIDENCE

NCHS

1. NAME: FIRST Kenneth MIDDLE LAST Wilson
2. SEX: MALE [X] 1 FEMALE [ ] 2
3A. DATE OF DEATH: MONTH 6 DAY 6 YEAR 2005
3B. HOUR: 3:30 AM

4A. PLACE OF DEATH: (Check one) HOSPITAL DOA [X] ER [ ] HOSPITAL OUTPATIENT [ ] HOSPITAL INPATIENT [ ] NURSING HOME [ ] PRIVATE RESIDENCE [ ] HOSPICE FACILITY [ ] OTHER (Specify): [ ]
4B. IF FACILITY, DATE ADMITTED: MONTH DAY YEAR

4C. NAME OF FACILITY: (If not facility, give address) SOUND SHORE MEDICAL CENTER
4D. LOCALITY: (Check one and specify) CITY [X] VILLAGE [ ] TOWN [ ] NEW ROCHELLE
4E. COUNTY OF DEATH: WESTCHESTER

4F. MEDICAL RECORD NO.: M2005-1215
4G. WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state) NO [X] YES [ ]

DECEDENT

5. DATE OF BIRTH: MONTH 12 DAY 31 YEAR 1968
6A. AGE IN YEARS: 36 yrs
6B. IF UNDER 1 YEAR ENTER: months days
6C. IF UNDER 1 DAY ENTER: hours minutes
7A. CITY AND STATE OF BIRTH: (If not USA, Country and Region/Province) Jamaica , Queens
7B. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH:

8. SERVED IN U.S. ARMED FORCES? (Specify yes/no) NO [X] 0 YES [ ] 1
9. DECEDENT OF HISPANIC ORIGIN? Check the boxes that best describe whether the decedent is Spanish/Hispanic/Latino. A [X] No, not Spanish/Hispanic/Latino B [ ] Yes, Mexican, Mexican American, Chicano C [ ] Yes, Puerto Rican D [ ] Yes, Cuban E [ ] Yes, Other Spanish/Hispanic/Latino (Specify)
10. DECEDENT'S RACE: Check one or more races to indicate what the decedent considered himself or herself to be: A [ ] White/Caucasian B [X] Black or African American C [ ] Asian Indian D [ ] Chinese E [ ] Filipino F [ ] Japanese G [ ] Korean H [ ] Vietnamese J [ ] Native Hawaiian K [ ] Guamanian or Chamorro M [ ] Samoan N [ ] American Indian or Alaska Native (specify) P [ ] Other Asian (specify) R [ ] Other Pacific Islander (specify) S [ ] Other (specify)
11. DECEDENT'S EDUCATION: Check the box that best describes the highest degree or level of school completed at the time of death. 1 [ ] ≤ 8th grade 2 [ ] 9th-12th grade; no diploma 3 [ ] High school graduate or GED 4 [ ] Some college credit, but no degree 5 [ ] Associate's degree 6 [X] Bachelor's degree 7 [ ] Master's degree 8 [ ] Doctorate/Professional degree

12. SOCIAL SECURITY NUMBER: 114-68-2549
13. MARITAL STATUS: NEVER MARRIED [ ] 1 MARRIED [X] 2 WIDOWED [ ] 3 DIVORCED [ ] 4 SEPARATED [ ] 5
14. SURVIVING SPOUSE: Enter name if married or separated. If surviving spouse is wife, enter maiden name. Michelle Field

15A. USUAL OCCUPATION: (Do not enter retired) Financial Advisor
15B. KIND OF BUSINESS OR INDUSTRY: Finance
15C. NAME AND LOCALITY OF COMPANY OR FIRM: Merrill Lynch

16A. RESIDENCE: (State or Country if not USA) New York
16B. County or Region/Province if not USA: Westchester
16C. LOCALITY: (Check one and specify) CITY [X] VILLAGE [ ] TOWN [ ] New Rochelle
16F. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? YES [ ] NO [ ] IF NO, SPECIFY TOWN:

16D. STREET AND NUMBER OF RESIDENCE: 70 BrookSide Place
16E. ZIP CODE: 10801

PARENTS

17. NAME OF FATHER: FIRST James MI Edward LAST Wilson
18. MAIDEN NAME OF MOTHER: FIRST Betty MI Lou LAST Elliott

19A. NAME OF INFORMANT: Michelle Wilson
19B. MAILING ADDRESS: (Include zip code) 70 Brookside Place New Rochelle, Ny 10801

DISPOSITION

20A. [X] 1 BURIAL [ ] 2 CREMATION [ ] 3 REMOVAL [ ] 4 HOLD [ ] 5 DONATION [ ] 6 ENTOMBMENT — MONTH 6 DAY 11 YEAR 2005
20B. PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION: Greenwood Union Cemetery
20C. LOCATION: (City or town and state) Rye, NY

21A. NAME AND ADDRESS OF FUNERAL HOME: George T Davis Funeral Home 14 Lecount Place New Rochelle, Ny 10801
21B. REGISTRATION NUMBER: 00690

22A. NAME OF FUNERAL DIRECTOR: Kirk Thompson
22B. SIGNATURE OF FUNERAL DIRECTOR: Kirk Thompson
22C. REGISTRATION NUMBER: 00673

23A. SIGNATURE OF REGISTRAR: Rita G. Colangelo, Dep.
23B. DATE FILED: MONTH 06 DAY 10 YEAR 2005
24A. BURIAL OR REMOVAL PERMIT ISSUED BY: Rita G. Colangelo
24B. DATE ISSUED: MONTH 06 DAY 10 YEAR 2005

ITEMS 25 THRO 33 COMPLETED BY CERTIFYING PHYSICIAN -- OR -- CORONER/CORONER'S PHYSICIAN OR MEDICAL EXAMINER

CERTIFIER

25A. CERTIFICATION: To the best of my knowledge, death occurred at the time, date and place and due to the causes stated.
Certifier's Name:
License No.: 111551
Signature:
Month 6 Day 7 Year 2005
Certifier's Title: 0 [ ] Attending Physician 0 [ ] Physician acting on behalf of Attending Physician 1 [ ] Coroner 2 [X] Medical Examiner / Deputy Medical Examiner
Address: Louis S. Roh, M.D. Westchester County Medical Examiner's Office, Valhalla,
25B. If coroner is not a physician, enter Coroner's Physician's name & title:
License No.:
Signature:
Month Day Year
25C. If certifier is not attending physician, enter Attending Physician's name & title:
License No.:
Address:

26A. Attending physician attended deceased: FROM Month Day Year TO Month Day Year
26B. Deceased last seen alive by attending physician: Month Day Year
26C. Pronounced Dead by M.E. or Coroner: ON Month 6 Day 6 Year 2005 AT Time 3:30 AM

27. MANNER OF DEATH: NATURAL CAUSE [X] ACCIDENT [ ] 2 HOMICIDE [ ] 3 SUICIDE [ ] 4 UNDETERMINED CIRCUMSTANCES [ ] 5 PENDING INVESTIGATION [ ] 6
28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? 0 [ ] NO 1 [X] YES
29A. AUTOPSY? NO [ ] 0 YES [X] 1 REFUSED [ ] 2
29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? 0 [ ] NO 1 [X] YES

CONFIDENTIAL — SEE INSTRUCTION SHEET FOR COMPLETING CAUSE OF DEATH — CONFIDENTIAL

CAUSE OF DEATH

30. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. IMMEDIATE CAUSE:
(A) CARDIAC HYPERTROPHY; PERICARDIAL EFFUSION
DUE TO OR AS A CONSEQUENCE OF:
(B)
DUE TO OR AS A CONSEQUENCE OF:
(C)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO - DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A):
DID TOBACCO USE CONTRIBUTE TO DEATH? 0 [ ] NO 1 [ ] YES 2 [ ] PROBABLY 3 [X] UNKNOW

31A. IF INJURY, DATE: MONTH DAY YEAR
HOUR:
31B. INJURY LOCALITY: (City or town and county and state)
31C. DESCRIBE HOW INJURY OCCURRED:
31D. PLACE OF INJURY:
31E. INJURY AT WOR NO [ ] 0 YES [ ] 1
31F. IF TRANSPORTATION INJURY, SPECIFY: 1 [ ] Driver/Operator 2 [ ] Passenger 3 [ ] Pedestrian
32. WAS DECEDENT HOSPITALIZED IN LAST 2 MONTHS? NO [ ] YES [ ]
33A. IF FEMALE: 0 [ ] Not pregnant within last year 1 [ ] Pregnant at time of death 2 [ ] Not pregnant, but pregnant within 42 days of death
33B. DATE OF DELIVERY: MONTH DAY YEAR

For use by physician or institution:
NAME OF DECEDENT: KENNETH WILSON
DATE OF DEATH: 6/6/05
TIME OF DEATH: 3:30 AM PM

Exhibit D

Northwestern Mutual

JEAN BERKA
Life Benefits Consultant
Life Benefits Division
Policyowner Services Department
1-800-635-8855 ext. 665-3070

July 21, 2006

Daniel Stein
Suite 101
3000 Westchester Ave
Purchase, NY 10577-2523

RE: Insured: Kenneth Wilson
Policy Number(s): 16852105

Dear Mr. Stein:

Please extend our belated sympathy to the family on death of Kenneth Wilson. Thank you for your patience while we reviewed the status of the policy on June 6, 2005.

We have thoroughly reviewed our records and our initial decision regarding policy 16852105 still stands. I am providing the events as they occurred to support that we complied with Mr. Wilson's request to terminate the coverage provided by this policy.

May 29, 2004- Policy 16852083 issued (Adjustable Complife/ACL)
Policy 16852105 issued companion Term 75

April 2005 Based on our records Mr. Wilson decided to drop the coverage on the ACL policy 16852083 which caused a loss of the companion status. This created a $35.00 policy fee to be added to the remaining policy.

May 23, 2005 Mr. Wilson called the Home Office questioning the shortage in his Insurance Service Account (ISA). We explained an additional fee of $35.00 was added to the payment due to the loss of the companion policy status. After hearing this, Mr. Wilson requested a refund of his last payment and allowed policy 16852105 to lapse. Our records indicate that we contacted you, Mr. Stein, and you agreed that this would be fine.

May 23, 2005 An automated ISA termination letter dated May 23, 2005, is mailed to Mr. Wilson. This letter shows the premium paid to date of May 29, 2005. This termination letter also stated that the end of the grace period was July 29, 2005. (This information is prior to refunding the February payment.)

May 30, 2005 Premium is manually backdated to February 28, 2005, as Mr. Wilson requested.

Exhibit E

Northwestern Mutual
720 East Wisconsin Avenue
Milwaukee, WI 53202-4797
(414) 271-1444

Account Number: 9695701
Prepared: May 23, 2005
110 71959

10162L2143000 0278Z000278
KENNETH WILSON
70 BROOKSIDE PL
NEW ROCHELLE NY 10801

Your Financial Representative
Daniel Stein
Suite 101
3000 Westchester Ave
Purchase NY 10577-2523
(914) 253-6426

General Agent
J Phllip Bender
Ste 200
285 Riverside Ave
Westport CT 06880-4806
(203) 221-5200

RE: Your Insurance Service Account (ISA) has been closed

Your ISA payment facility has been closed because all policies in the account have been removed.

Closing this payment facility means you will receive an individual notice for the policy listed below. This policy remains in effect until the end of its grace period. At that time, if payment has not been received, the policy's non-payment provision becomes effective. See the policy contract to determine the non-payment provision. Please refer to the back of this letter for an explanation of terms used.

Insured Name	Policy Number	Policy Paid-to-Date on Closing Day	End of Grace Period
Kenneth Wilson	16-852-105	May 29, 2005	June 29, 2005

Please call your Financial Representative at (914) 253-6426 or our Policyowner Services Department at the Home Office for further information or assistance.

PROOF OF SERVICE

STATE OF NEW YORK)
COUNTY OF NEW YORK)

I, EDWARD McCARTHY maintain my offices in the City of Newburgh, County of Orange, State of New York. I am over the age of 18 and not a party to these proceedings. My business address is 96 Broadway, City of Newburgh, Newburgh, New York 12550.

On May 23, 2007, I served the Annexed documents: Plaintiff's First Amended Complaint on all interested parties at the addresses that follow:

***** PLEASE SEE ATTACHED SERVICE LIST*****

_X_ VIA OVERNIGHT MAIL:

By delivering such documents to an overnight mail service or an authorized courier in a sealed envelope or package designated by the express courier addressed to the person(s) on whom it is to be served.

____VIA U.S. MAIL:

By depositing a sealed envelope containing the above-cited document with the U.S. Postal Service on _____ with postage thereon fully paid at the local post office in Newburgh, New York.

____VIA PERSONAL DELIVERY:

By personally delivering such sealed envelope by hand to the offices of the addressee pursuant to the applicable law

____VIA FACSIMILE:

By facsimile transmission where a report was generated indicating that the transmission was completed to the number indicated on the report without error.

I declare under penalty of perjury under the laws of the United States of America that the above is true ad correct and I declare that I did so at the direction of the member of the bar of this Court at whose direction the service was made.

Executed this 23rd h day of May 2007, City of Newburgh, County of Orange, State of New York.

EDWARD McCARTHY

SERVICE LIST

WILSON V. NORTHWESTERN Case No.: 07cv2790-(CLB)

RIVKIN RADLER LLP
Attorneys for Defendant
Attn: Norman L. Tolle, Esq., of Counsel
926 Reckson Plaza
Uniondale, New York 11556-0926
Tele: 516.357.3000
Fasc: 516.357.3333

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

MICHELLE WILSON, Plaintiff, vs. NORTHWESTERN MUTUAL INSURANCE COMPANY, Defendants.	Case No.: 07CV2790 (CLB) HON. CHARLES L. BRIEANT

* * *

PLAINTIFF'S FIRST AMENDED COMPLAINT

Law Office of DOUGLAS R. DOLLINGER
Attorney for Plaintiff(s)
96 Broadway
City of Newburgh
Newburgh, New York 12550
Tele: 845.562.9601
Facs: 845.562.9602

To:
Rivkin Radler LLP
Attorneys for Defendant(s)
926 Reckson Plaza
Uniondale, New York 11556-0926